COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS
James J. Campbell, Commissioner
600 WASHINGTON STREET
BOSTON, MA 02111

INFORMATION AND APPLICATION

FOR

452 CMR 6.00

UTILIZATION REVIEW AND QUALITY ASSESSMENT PROGRAM

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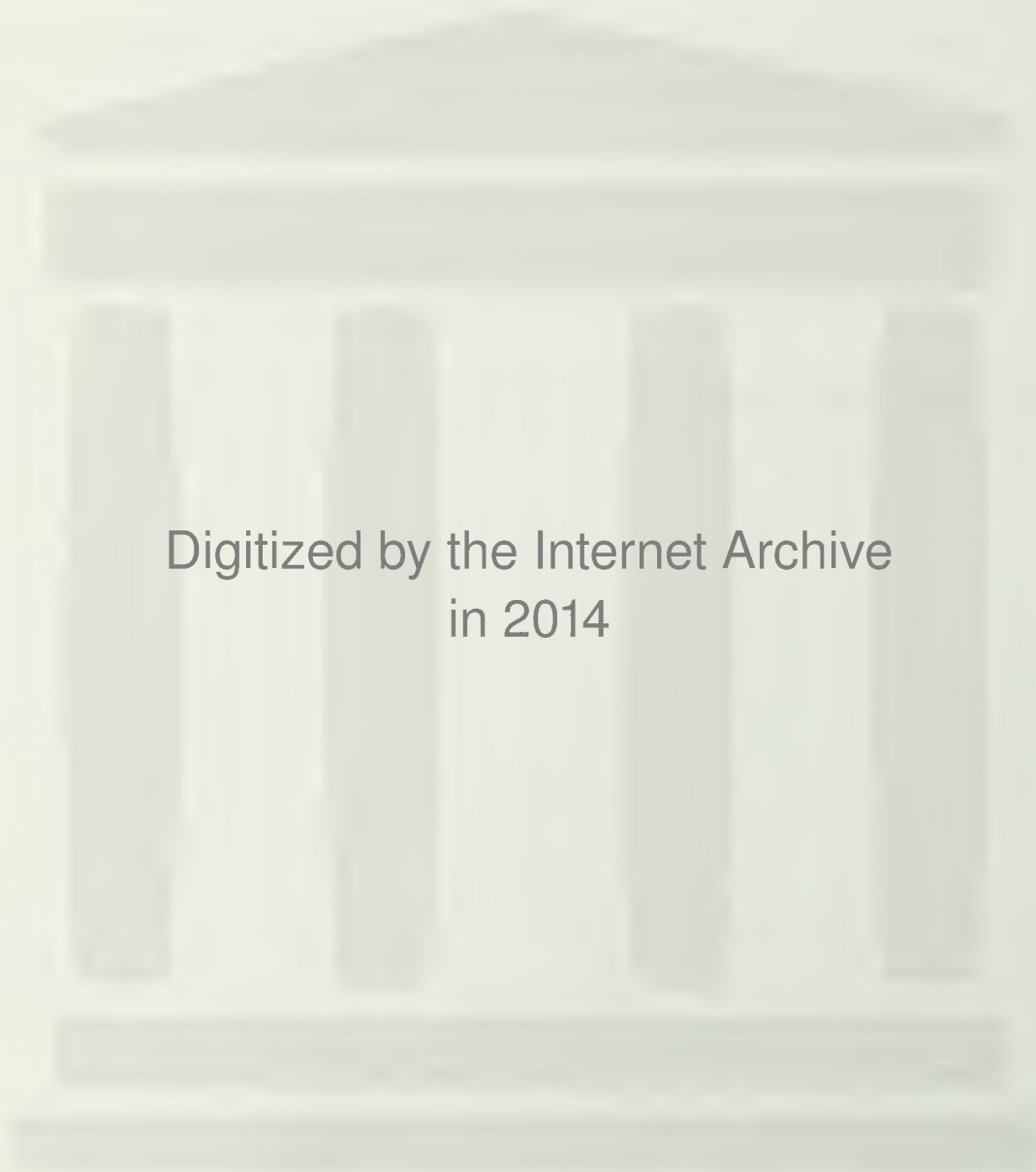
Approved by: Philmore Anderson III, State Purchasing Agent



SECTION 1:

INTRODUCTION

BY:

COMMISSIONER JAMES J. CAMPBELL

INTRODUCTION

In 1991, a major piece of Workers' Compensation reform legislation was signed by Governor Weld. This new legislation (Massachusetts General Laws Chapter 152, as amended by Chapter 398 of the Acts of 1991), provided a new direction in health care policy with respect to workers' compensation. Central to this new policy is the Department of Industrial Accident's (DIA) implementation of a utilization review program to monitor the extent to which medical care delivered is necessary and appropriate. Further, the statute enhanced the responsibilities of the Health Care Services Board (HCSB), whose members are appointed by the Commissioner of the DIA, and a Consortium of Medical Consultants (MCC) was formed to advise the DIA on the total range of care of injured employees and other health care related matters.

The new Act required the HCSB to develop written guidelines for appropriate and necessary treatment of injuries and illnesses. The development process was undertaken by a group of professionals dedicated to the implementation of adequate and reasonable health care. Troyen A. Brennan, M.D., J.D., a member of the MCC, and architect of the utilization review program, established a Clinicians Guideline Committee to develop the guidelines for the HCSB. Members on the committee were representative of the varied professions treating workers compensation related injuries. Edwin Wyman, M.D. chaired the committee toward development of the most recent version of the guidelines promulgated on July 1, 1993.

These treatment guidelines or practice algorithms are a part of a new direction in health care policy, and are optimal strategies for patient management around which practice patterns should converge. To avoid differences in potentially confusing and inconsistent interpretation of guidelines, a set of review criteria accompany the guidelines. The treatment guidelines have been endorsed by the HCSB, and both the guidelines and the review criteria are now a mandatory component of the utilization review program and regulations. The Act provides for annual review and revision of the guidelines, where appropriate, reflecting an ongoing process of guideline creation and updating.

The guidelines are derived from multiple sources. The Committee adopted Guidelines 1 and 2 from the American Academy of Orthopedic Surgeons. Guidelines 20, 21, 23 and 24 were developed by the Committee. The remaining guidelines were adopted from a set of treatment protocols developed by the State of Washington Department of Labor and Industries, Industrial Insurance Division. The review criteria were developed by the DIA with the assistance of an outside contractor.

The DIA has developed a Clinical Information Form to be used by providers and utilization review agents to facilitate utilization review and payment to providers. The Form captures the clinical data which are included in the treatment guidelines and derivative review criteria. Use of the form in tandem with other reporting requirements is not required, but strongly encouraged.

In closing, I would like to thank everyone who has participated in bringing the utilization review program to this point. DIA staff, as well as the various professionals, have devoted many hours to the projects, under the extremely limiting time constraints imposed by the new Act. In addition, I want to thank all of you for your continuing input and efforts as the DIA continues implementation of this and other provisions of the Act.

James J. Campbell
Commissioner

SECTION 2:

CIRCULAR LETTER NO. 270

James J. Campbell
Commissioner

The Commonwealth of Massachusetts

Department of Industrial Accidents
600 Washington Street
Boston, Mass. 02111

CIRCULAR LETTER NO. 270

TO: ALL INTERESTED PARTIES

FROM: JAMES J. CAMPBELL, COMMISSIONER

RE: 1) Utilization review and quality assessment regulations regarding the provision of adequate and reasonable health care services,
2) Promulgation of amended and new treatment guidelines for appropriate and necessary treatment based on diagnosis of injuries and illnesses,
3) Review criteria to be applied to the guidelines,
4) Clinical information form, and
5) Application for approval of utilization review programs

DATE: July 1, 1993

Newly amended treatment guidelines relating to appropriate and necessary treatment based on diagnosis of injuries and illnesses for use by health care providers in the treatment of injuries and illnesses under M.G.L. c. 152 - published in original form on July 1, 1992 pursuant to the provisions of M.G.L. c. 152, §13, as most recently amended by St. 1991, c. 398, §34, endorsed and amended in January 1993 and referenced in Circular Letter No. 268, as well as new treatment guidelines have been endorsed by the Health Care Services Board and adopted by the Commissioner of the Department of Industrial Accidents. For each treatment guideline, the Department has also created and developed utilization review criteria to be applied to the guidelines.

Pursuant to the provisions of M.G.L. c. 152, §30, as most recently amended by St. 1991, c. 398, §53, utilization review and quality assessment regulations relating to the provisions of adequate and reasonable health care services were promulgated on June 18, 1993, effective July 1, 1993. Utilization review programs shall integrate the treatment guidelines and apply the review criteria. Pursuant to the regulations, all utilization review programs must be approved by the Department, on an application form prescribed by the Department, prior to undertaking utilization review for any and all health care services rendered on or after October 1, 1993.

Copies of the treatment guidelines, the review criteria, th regulations, and the application for approval of utilization review programs as well as any and all further amendments and additions to these guidelines and review criteria are available through the Department's Office of Health Policy, extension 438.

In addition, on or before October 1, 1993, the Department will have available the following: a comprehensive utilization review manual containing all of the above as well as related materials, and a clinical information form for each treatment guideline and review criteria. The form has been developed to b used by providers and utilization review agents to facilitate utilization review and payment to providers. Use of the form is not mandatory and not in lieu of other reporting requirements, b is strongly recommended.

SECTION 3:

REVIEW PROCEDURES

FOR

APPLICATION FOR APPROVAL

OF

UTILIZATION REVIEW AND QUALITY ASSESSMENT PROGRAM

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS
OFFICE OF HEALTH POLICY
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111
617/727-4900, Extension 438

REVIEW PROCEDURES FOR APPLICATION FOR APPROVAL OF UTILIZATION REVIEW AND QUALITY ASSESSMENT PROGRAM

1. The application must be complete, typewritten, and forwarded to:

   Donna Ward
   Office of Health Policy
   Department of Industrial Accidents
   600 Washington Street
   Boston, MA 02111

2. The application will be reviewed for completeness at the Department of Industrial Accidents ("DIA"). Within 30 days of receipt, the applicant will be notified of approval or non-approval. If the document is incomplete, the entire application will be returned.

3. Approved applicants will receive a written notification of approval including an assigned identification number. Any companies listed in the application who provide utilization review systems, services, and/or medical bill adjustments on behalf of the approved applicant will also be assigned identification numbers.

4. Approval will be for a 2 year period; however, in accordance with 452 CMR 6.04, notification must be made to the DIA in writing of any and all material changes to required information, including contractual relationships, within (30) days of said changes. Failure to notify the DIA of changes may result in the revocation of any approval to conduct Utilization Review in Massachusetts.

5. Applicants that are not approved will have their application returned with notification of the reasons for non-approval. Applicants may appeal the decision by submitting a written request for appeal to the Health Care Services Board ("HCSB"), c/o the Department of Industrial Accidents, Office of Health Policy, attention Donna Ward, within thirty (30) days of the notification of non-approval. The request for appeal must state the reasons for the appeal.

6. The HCSB will review the appealed application and provide written notification of its decision to the applicant within thirty (30) days of receipt of the application.

7. Decisions of the HCSB may be appealed to the Commissioner of the DIA by submitting a written request for appeal to the Commissioner within thirty (30) days of notification of the HCSB decision. The request for appeal must state the reasons for appeal.

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS
OFFICE OF HEALTH POLICY
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111
617/727-4900, Extension 438

APPLICATION FOR APPROVAL OF
UTILIZATION REVIEW AND QUALITY ASSESSMENT PROGRAM

NAME OF UTILIZATION REVIEW AGENT: _____
d/b/a: _____
ADDRESS: _____
NUMBER OF SITES/PRINCIPAL SITES: _____
TEL. NO.: (REGULAR NO.): _____ (TOLL FREE NO.): _____
CONTACT PERSON: _____ TEL. NO.: _____
NORMAL BUSINESS HOURS: _____

NOTE: If more space is needed, applicants may submit additional pages. In doing so, please refer to the sections as numbered herein.

I. REVIEW CRITERIA:

1. State the sources of review criteria (name of utilization review agent or whether internally derived).

   ☐ internally derived
   ☐ proprietary firm; name _____

2. State the types of criteria.

   ☐ diagnostic
   ☐ treatment
   ☐ other; describe _____
   _____

3. Describe your process for revisions to protocols and/or decision rules for utilization review determinations.

   _____
   _____
   _____

4. How frequently are revisions to protocols and/or decision rules for utilization review determinations made?

- ☐ more than once a year
- ☐ at least annually
- ☐ at least once every two years
- ☐ less than once every two years

5. Are your criteria publicly available?

- ☐ no
- ☐ yes
  - ☐ to physicians ☐ to clients
  - ☐ to the public ☐ to hospitals

II. REVIEW PROGRAM:

1. Describe procedures for conducting utilization review, and include specific procedures for retrospective, concurrent, and prospective review.

_____

_____

_____

2. Attach a written description of the flow of your utilization review systems.

- ☐ copy attached

3. Does your company have any quality assurance monitoring process to improve or maintain the quality of your review decisions?

- ☐ no
- ☐ yes, describe _____

_____

III. REVIEWER QUALIFICATIONS:

1. Do members of your professional review staff hold current professional licenses by the appropriate state licensing agency?

- ☐ no, explain _____
- ☐ yes

2. How many professional review staff are assigned to each job title or category of professional reviewer?

Physicians	___	Accredited Record Technicians	___
Registered Nurses	___	Registered Record Technicians	___
LPNs	___	Other, and state title(s)	___

3. Will each practitioner, as defined in the utilization regulations, rendering Workers' Compensation utilization review determinations be providing patient care at least 8 hours per week?

☐ no
☐ yes

4. Do you provide any economic incentives to achieve cost savings for any utilization reviewers in your Workers' Compensation utilization review programs?

☐ no
☐ yes, describe or attach a copy _____
_____
☐ copy attached

5. List all entities with whom you subcontract for the provision of services or systems such as: claims processing, claims adjusting, etc., specifying the service each provides.

_____
_____
_____

6. List all entities with whom you are currently under contract to perform Workers' Compensation utilization review.

_____
_____
_____

IV. UTILIZATION REVIEW DETERMINATIONS AND APPEAL PROCEDURES:

1. Provide a copy of the materials sent to a practitioner and/or the employee to inform them of the utilization review program and appeal procedures.

☐ copy attached

2. Do you issue the employee a card listing all of the following: Employee Name, Identification Number, Name and Telephone Number of Utilization Review Agent and Insurer?

☐ no, explain _____
☐ yes, attach copy of sample card

3. Provide the process for notification of adverse determinations to provider and injured employee.

_____
_____
_____

4. Do notifications of adverse determinations include the review criteria used and the reasons for the determination?

☐ no, explain _____
☐ yes

5. Provide a detailed description of the appeal procedures by which a practitioner and/or injured employee may seek review of a utilization review agent's determination.

_____
_____
_____

6. Describe your system for telephone appeal of an adverse determination made prior to or during an ongoing service requiring review.

_____
_____
_____

7. Is your utilization review staff available by toll free telephone at least 40 hours per week between 9:00 a.m. to 5:00 p.m., EST?

☐ no
☐ yes

8. Describe your telephone system for the receipt of telephone calls during other than normal business hours.

☐ staff available
☐ answering machine
☐ facsimile machine
☐ other; describe _____

V. PREFERRED PROVIDER ARRANGEMENTS

1. If the insurer has received approval of a preferred provider arrangement (PPA) through the Division of Insurance, please so indicate and provide the following information.

☐ no
☐ yes, the following is attached

- ☐ the information provided to employees regarding their rights and obligations;
- ☐ the list of names of providers on the PPA; and
- ☐ the complete PPA information filed with the Division of Insurance (DOI) and a copy of the DOI approval letter.

VI. GENERAL REQUIREMENTS

1. Identify your professional liability and other insurance coverage limits.

_____
_____
_____

2. Are you presently involved in any disputes and/or litigation which relate to your performance of utilization review?

☐ no
☐ yes, explain _____
_____

3. Has your utilization review program been approved by:

☐ URAC
☐ Other States

VII. CONFIDENTIALITY AND OTHER APPLICABLE LAWS:

In submitting this application, the utilization review agent certifies that it shall comply with all applicable Massachusetts and federal laws, including, but not limited to, those laws which protect confidentiality of medical records.

BY: _____
Company Name

_____
Authorized Representative

_____
Title

_____
Date

SECTION 4:

UTILIZATION REVIEW REGULATIONS

452 CMR 6.00

452 CMR 6.00: UTILIZATION REVIEW AND QUALITY ASSESSMENT

Section

6.01: Scope and Authority

452 CMR 6.00 is promulgated pursuant to M.G.L. c. 152, ss. 5, 13 and 30 as most recently amended by St. 1991, c. 398. 452 CMR 6.00 is effective July 1, 1993 and shall apply to all claims irrespective of date of injury for health care services rendered on or after October 1, 1993. 452 CMR 6.00:

(a) requires workers' compensation insurers to undertake utilization review;
(b) references the guidelines and review criteria that the Department of Industrial Accidents (DIA) requires providers to follow when treating certain medical conditions, and set forth the mechanism for the development, endorsement, dissemination, and implementation of future guidelines;
(c) sets forth the nature of utilization data that must be reported to the Department of Industrial Accidents;
(d) sets forth the methods for quality assessment that will be used by the Department of Industrial Accidents; and
(e) sets forth the nature of the mechanisms that DIA will use to ensure compliance with 452 CMR 6.00.

6.02: Definitions

Adverse Determination means the denial of coverage for a treatment plan, including diagnosis or therapy.

Authorization means notification by an insurer to the provider that specific, medically necessary health care services will be reimbursed by the insurer pursuant to M.G.L. c. 152.

Bill means a request by a provider that is submitted to an insurer or utilization review agent for payment for health care services that are provided in connection with a compensable injury or illness pursuant to M.G.L. c. 152.

Case Record means the complete health care record that is maintained by the insurer and pertains to an employee's injury or illness. The case record shall include all the following information and documents: the circumstances or reasons for seeking health care, all bills filed by the provider, and any actions of the insurer.

Commissioner means the Commissioner of the Department of Industrial Accidents (DIA).

Department means Department of Industrial Accidents (DIA).

Detailed Description of Services Rendered means pursuant to M.G.L. c. 152, s. 13 a report demonstrating the diagnosis, medical appropriateness of the service, pertinent physical findings, diagnostic and therapeutic procedures, prognosis, concurrent problems, and follow-up care; the injured employee's functional limitations, the ability to perform either regular duties, limited duties, full or part time hours and/or whether the medical condition is at a point of maximum medical improvement.

Diagnostic Procedure means a service that aids in determining the nature and cause of a disease or injury.

Diagnostically Related Groups means codes that refer to certain classes of diagnoses for prospective payment purposes by which health care providers are paid a pre-set amount for treatment of a particular medical ailment.

6.02: continued

Dispute means a disagreement between an insurer, an employee, a provider or any other party concerning the application of M.G.L. c. 152.

Emergent Admission means placement of an employee in a facility for the care of a work-related medical condition of an unforeseen or rapidly progressing nature.

Facility means any location intended as a site for medical treatment.

Functional Status means the standardized measurement of a patient's self-reported ability to function including, but not limited to, Medical Outcome Study Short Form (MOS-SF) - 36.

Guidelines mean optimal strategies for patient management around which practice patterns should converge.

Health Care Services means treatment services rendered to an injured employee by a provider pursuant to M.G.L. c. 152.

Health Care Services Board means the Board created by M.G.L. c. 152, s. 13(3).

Injury means personal injury as defined in M.G.L. c. 152, s. 1(7A).

Inpatient Care means that care which requires an employee to stay overnight in a facility.

Insurer means an entity defined in M.G.L. c. 152, s. 1(7) and any self-insured group as defined in M.G.L. c. 152, s. 25(E)-(U).

Medical Condition means the physical or mental health status of an injured employee as determined by the provider administering health care services.

Medical Release means a signed release by the injured employee authorizing release of all relevant medical information regarding the injury.

Medical Report means a report of the Initial Industrial Accident office visit as defined in 114.3 CMR 40.03 pursuant to 452 CMR 1.13(1).

Non-emergent (Elective) Admission means placement of the employee in a facility for care of a condition which may be appropriately scheduled in advance.

Outpatient Care means that care which does not require an overnight stay in a facility.

Patient Satisfaction Measurement means use of a standard patient questionnaire form, including, but not limited to, the American College of Physicians questionnaire to determine a particular individual's satisfaction with his or her care.

Practitioner means a person who is a physician or dentist as defined by M.G.L. c. 233, s. 79G.

Preferred Provider Arrangement means a contract between or on behalf of an organization and health care provider(s), as defined by M.G.L. c. 176I, 211 CMR 112.00 and M.G.L. c. 152, to provide all or a specified portion of health care services resulting from workers' compensation claims against such organizations by covered persons.

Procedure means a unit of health care service.

Provider means a practitioner, facility, or other organization providing health care services.

School means a grouping of practitioners as defined by their professional degree. Schools include, but are not limited to, physical and occupational therapy, chiropractic, osteopathic, allopathic, nursing and dentistry.

6.02: continued

Utilization Review means a system for reviewing the appropriate and efficient allocation of health care services given to a patient or group of patients as to necessity, for the purpose of recommending or determining whether such services should be covered or provided by an insurer, provider, nonprofit service organization, third-party administrator or employer. Included are those programs or processes whether they apply prospectively, concurrently, or retrospectively to health care services. Utilization review services include, but are not limited to, the following: second opinion programs; pre-hospital admission certification; pre-inpatient service eligibility certification; and concurrent hospital review to determine appropriate length of stay.

Utilization Review Agent means any person or entity, including the Commonwealth of Massachusetts or any insurer which has developed its own utilization program, performing utilization review. Utilization review agent shall not mean an agency of the federal government; or an agent acting on behalf of the federal government, but only to the extent that the agent is providing services to the federal government; or a hospital's internal quality assurance program; or health maintenance organizations licensed and regulated by the Commissioner of the Division of Insurance, but only to the extent of providing utilization review to their own members.

6.03: Preferred Provider Arrangements under Workers' Compensation

(1) If an insurer receives approval of a preferred provider arrangement (PPA), an injured employee shall, if the arrangement is consented to by the employer and includes a provider in the specialty sought by the employee, be required to see a member of the preferred provider arrangement on the initial scheduled visit. Employees subject to any arrangement shall be provided information regarding their rights and obligations under M.G.L. c. 152, s. 30 and M.G.L. c. 176I upon initial approval of the preferred provider arrangement and annually thereafter. Such information shall also be posted in a prominent place in all worksites.

(2) The list of names of the providers in the preferred provider arrangement within an employee's geographic region or of all health care providers within the arrangement organized geographically shall be distributed to each covered employee immediately following an alleged workplace injury. The names on such lists shall be arranged in order of medical specialty or provider type. A current list shall also be posted at a convenient and prominent place for covered persons to examine at worksites, and shall be given to any covered person upon request.

(3) Any insurer approved as a preferred provider arrangement for workers' compensation must send to the Department of Industrial Accidents a duplicate copy of all information filed with the Division of Insurance together with a copy of its approval letter.

(4) The Department of Industrial Accidents may require the approved PPA applicant to survey affected employees with a form of the Department's design to assess the employee's understanding of their rights with regard to participation in PPA's.

6.04: Utilization Review by Insurers

(1) Insurers must either contract with agents who provide utilization review services to develop utilization review programs or develop their own utilization review programs for both outpatient and inpatient health care services. These programs may include, but not be limited to: prospective, concurrent or retrospective review; second opinion programs; or mandatory ambulatory surgery programs.

For the conditions to which the treatment guidelines endorsed by the Health Care Services Board and adopted by the Commissioner pursuant to M.G.L. c. 152, ss. 13 and 30 apply, the programs shall integrate said treatment guidelines. The only utilization review criteria which can be applied relative to medical conditions addressed by said treatment guidelines are those criteria published by the Department.

6.04: continued

(2) To conduct utilization review in the Commonwealth, a utilization review agent must request approval of its utilization review program from the Commissioner in writing and shall file the following information:

(a) The name, address, telephone number, contact person, and normal business hours of the utilization review agent;

(b) Review criteria: source(s) of criteria, (name of utilization review agent or whether internally derived), type(s) of criteria (i.e., diagnostic, treatment), process for and frequency of revisions, protocols and/or decision rules for utilization review determinations, and public availability of criteria;

(c) Current professional licenses issued by the appropriate state licensing agency for all providers rendering utilization review determinations;

(d) A detailed description of the appeal procedures for utilization review determinations, a copy of the materials designed to inform employees of the requirements of the utilization review program and the responsibilities and rights of employees under the program; and

(e) Disclosure of any economic incentives for reviewers in the utilization review program.

Any material changes in the information filed in accordance with 452 CMR 6.04 shall be filed with the Commissioner within 30 days of said change. The utilization review agent shall comply with all applicable laws, rules, regulations, ordinances, orders or requirements of the Commonwealth.

(3) The Department will annually publish the list of approved utilization review agents, and the nature of their utilization review programs.

(4) All utilization review agents shall, at a minimum, meet the following standards:

(a) Any adverse determination by a utilization review agent as to an admission, service, or procedure following the health care providers' submission of a detailed description of the services rendered, as required by M.G.L. c. 152, s. 13, shall be reviewed by a practitioner as defined in 452 CMR 6.02. When the service is one ordered by a practitioner, such review shall be conducted by a practitioner in the same school;

(b) Notification of all adverse determinations by the utilization review agent shall be communicated to the provider of record and the injured employee or other appropriate individual in writing. For prospective review, notice must occur within two business days of the receipt of the request for determination and the receipt of all information necessary to complete the review. For concurrent review, the notification should be within one day prior to implementation (i.e., discharge) and for retrospective review, the notification should be within ten days of the adverse determination;

(c) Any notification to the provider and the injured employee of an adverse determination must include the review criteria and all the reasons for the determination and the procedure to initiate an appeal of the determination. Utilization review agents shall maintain and make available a written description of the appeal procedure by which the attending practitioner and/or the injured employee may seek review of a determination by the utilization review agent. The appeal procedure, at a minimum, shall provide for the following:

1. When an adverse determination not to approve a health care service is made prior to or during an ongoing service requiring review, and the injured employee and/or the provider believes that the determination warrants immediate appeal, the injured employee and/or the provider shall have an opportunity to appeal that determination over the telephone to the utilization review agent, with the right to speak to a practitioner of the same school on an expedited basis, said appeal to occur not later than 30 days from the date of receipt of notice of adverse determination. Utilization review agents shall complete the adjudication on an expedited basis, but at least within two business days of the date the appeal is made;

2. Utilization review agents shall complete the adjudication of all other appeals of adverse determinations no later than 20 days from the date the appeal is filed;

(d) Utilization review agents shall make staff available by toll-free telephone at least 40 hours per week between the hours of 9:00 AM to 5:00 PM, EST;

6.04: continued

(e) Utilization review agents shall have a telephone system capable of accepting or recording incoming telephone calls during other than normal business hours and shall respond to these calls within two business days of its receipt. If the utilization review agent maintains a pre-certification program, then telephone contact shall be available 24 hours a day. Once an insurer has commenced payments for a work related injury under M.G.L. c. 152, it must issue the employee a card listing the employee name, an identification number assigned to the employee, the name and telephone number of the utilization review agent, and the name of the insurer. When the employee seeks further care, he or she must contact the utilization review agent for approval. In the case of an emergency, utilization review agents shall allow a minimum of 24 hours after an emergency admission, service, or procedure for an injured employee or injured employee's representative to notify the utilization review agent and request approval for treatment;
(f) Utilization review agents shall comply with all applicable laws to protect the confidentiality of medical records and, where necessary, obtain a medical release; and
(g) Practitioners rendering utilization review determinations must provide patient care for at least eight hours per week.

(5) After exhaustion of the process set forth in 452 CMR 6.04(4)(c) appealing the determination of the utilization review agent, or if payment of an approved claim has not been issued within 45 days, a party may file a claim or complaint in accordance with 452 CMR 1.07 under the provisions of M.G.L. c. 152, ss. (8)(4) and/or 10.

(6) Injured employees may be liable for care subsequent to the adverse determination after they have been notified of that adverse determination.

6:05: Utilization Reporting

(1) Beginning January 1, 1994, providers must use, and insurers must accept, standard forms prescribed by the DIA, based on the most recent Universal Billing (UB) form and the Health Care Financing Administration (HCFA) 1500 billing form.

(2) The Department may require utilization review agents to provide a sample of up to 100% of all billing records, both inpatient and outpatient, which sample shall be transmitted to the Department of Industrial Accidents so that the Department can implement appropriate utilization oversight. In addition to the standard billing file, for every outpatient service the Department may request information about the insurer, any procedures, and the employer's and provider's identification numbers. For inpatient services, the Department must receive all relevant diagnostic and procedure International Classification of Disease (ICD) 9-CM, Current Procedural Terminology (CPT) and other codes, the length of stay and the cost of any ancillary services. The Department may require both counts of services as well as the amount reimbursed.

6.06: Treatment Guideline and Review Criteria Development

(1) The Health Care Services Board will review and update treatment guidelines at least annually. Providers shall follow the treatment guidelines endorsed by the Health Care Services Board and adopted by the Commissioner when caring for injured employees or risk nonpayment. The guidelines should not be construed as including all proper methods of care reasonably directed to obtaining the same results. The ultimate judgement regarding any specific procedure or treatment must be made by the provider in light of all circumstances presented by the injured employee and the needs and resources particular to the locality or facility. The adopted guidelines shall be used by utilization review programs administered by insurers in a form required by the Department.

(2) For each treatment guideline, the Department shall create and develop utilization review criteria to be applied to the guideline. The review criteria will be reviewed at least annually with each guideline.

6.07: Quality Assessment and Enforcement

(1) The Department of Industrial Accidents will monitor the quality of care rendered to injured employees using a combination of conventional outcome measures, medical record audits, analysis of employee health status and patient satisfaction measurements. The Department shall monitor the performance of providers reimbursed by insurers.

(2) The Department of Industrial Accidents will gather data on compliance with the treatment guidelines through reports from insurers and utilization review agents. If a provider's care is demonstrated to be statistically significantly outside a particular guideline, the provider will be informed of this by the Department and educational material regarding the guideline will be transmitted to the provider. On a periodic basis, the provider's utilization patterns will then be reassessed. If the provider remains statistically significantly outside the guideline, the provider will be warned by the Department, educational materials will again be transmitted, and a clinical evaluation performed. If the provider's care is found to remain significantly and frequently outside the guideline, the matter will be transferred to the Commissioner. At the discretion of the Commissioner, the matter may be referred to the Health Care Services Board which may then refer the matter to the appropriate Board of Registration.

(3) If the Department finds that the care provided to injured employees through an insurer is more frequently deficient than that provided to other employees in receipt of workers' compensation, the Department will address this issue with the insurer in a manner similar to the one specified in 452 CMR 6.07(2), with the exception that any referral by the Health Care Services Board will be to the Division of Insurance instead of a Board of Registration.

(4) The Department shall monitor the utilization review techniques used, and determinations made, by utilization review agents. If the Commissioner receives a complaint from a practitioner, employer, or employee, or has reason to believe that a utilization review agent has been or is engaged in conduct that violates these regulations, the Commissioner shall notify the utilization review agent in writing of the alleged violation. The utilization review agent shall have 30 days from the date the notice is received to respond to the alleged violation and request a hearing. Upon receipt of said request, the Commissioner, or his designee, shall schedule a hearing. The hearing shall be conducted pursuant to M.G.L. c. 30A. If, after the hearing, the Commissioner determines that the utilization review agent has violated or is in violation of 450 CMR 6.00, the Commissioner shall issue an order requiring the insurer and/or utilization review agent to cease and desist from engaging in the violations. The Commissioner may also suspend or revoke his approval of the utilization review agent's ability to conduct utilization review.

REGULATORY AUTHORITY

452 CMR 6.00: M.G.L. c. 152, ss. 5, 13 and 30.

SECTION 5:

TREATMENT GUIDELINES

EFFECTIVE JULY 1, 1993

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

TREATMENT GUIDELINES
EFFECTIVE JULY 1, 1993

GUIDELINE LIST

Guideline Number 1*	Carpal Tunnel Syndrome Conservative Non-Operative Treatment
Guideline Number 2*	Carpal Tunnel Release
Guideline Number 3**	Thoracic Outlet Syndrome Vascular Origin - Venous
Guideline Number 4**	Thoracic Outlet Syndrome Vascular Origin - Arterial
Guideline Number 5**	Thoracic Outlet Syndrome Neurogenic Origin
Guideline Number 6**	Rotator Cuff Repair Shoulder
Guideline Number 7**	Anterior Acromionectomy for Acromial Impingement Syndrome Shoulder
Guideline Number 8**	Repair of AC or CC Ligaments Acromio-Clavicular Separation Shoulder
Guideline Number 9**	Mumford Procedure Acromio-Clavicular Separation Shoulder
Guideline Number 10**	Open Bankart or Bristow for Recurrent Dislocation Shoulder
Guideline Number 11**	Repair of Biceps Tendon Proximal Rupture of the Biceps Shoulder
Guideline Number 12**	Repair of Biceps Tendon Distal Rupture of the Biceps Shoulder
Guideline Number 13**	Shoulder Arthroscopy for Diagnostic Purposes Shoulder
Guideline Number 14**	Anterior Cruciate Ligament (ACL) Repair Knee
Guideline Number 15**	Patella Tendon Re-Alignment Maquet Procedure Knee

Guideline List

* Developed by the American Academy of Orthopaedic Surgeons

** Developed by the State of Washington Department of Labor and Industries

*** Developed by the Department of Industrial Accidents Health Care Services Board Clinicians Guideline Committee

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GUIDELINE NUMBER 1 - CARPAL TUNNEL SYNDROME
CONSERVATIVE NON-OPERATIVE TREATMENT

I. Background

Carpal Tunnel Syndrome, also known as tardy median nerve palsy, is believed to be caused by local impairment of the median nerve at the carpal canal in the wrist secondary to narrowing or crowding of the nerve in the carpal tunnel. The condition may have multiple causes including 1) space-occupying lesions such as the residual of a wrist fracture, infections, local edema, tumors, flexor tenosynovitis (non-specific as well as that associated with rheumatoid arthritis), foreign bodies, or aberrant muscles; 2) systemic conditions such as pregnancy, obesity, diabetes mellitus, thyroid dysfunction, arthritis, or amyloidosis; 3) overuse of hand and wrist, work-related trauma and repetitive movements, constricting bandages around the wrist, or improper postural habits regarding the wrist joint; or 4) it may have a spontaneous or idiopathic onset. The condition can occur at any age but it most often encountered in patients over 30 years in age. It occurs three to five times more frequently in women than men.

II. Diagnostic Criteria

A. Pertinent Historical and Physical Findings

Patients complain of paresthesias and numbness in all or part of the sensory distribution pattern of the median nerve in the hand, which often worsen at night when lying in bed. These sensations are occasionally associated with pain that may radiate proximally to the shoulder area. The most characteristic history involves nocturnal paresthesias, described frequently as sensations of burning or numbness that may be relived by shaking or holding the affected arm in the dependent position. Weakness of grip, hypohidrosis, clumsiness and proximal pain migration may be accompanying complaints. Wrist palmar flexion may aggravate the symptoms, and the patient may note difficulty manipulating small objects. Occasionally, patients may complain of circulatory disturbances in the fingers.

Symptoms may be reproduced by hand and wrist motions, such as forced flexion and extension of the wrist, that constrict the carpal canal. This tendency forms the physiologic basis for the Phalen test, which may be positive in the presence of median nerve compression at the wrist. The patient may exhibit dryness of the skin on the hand and fingers, thenar muscle atrophy of fasciculations, and decreased pinch or grip strength. There may be increased median nerve two-point discrimination. Tinel's sign may be positive. These tests are strongly corroborative, but their absence does not exclude this diagnosis.

B. Appropriate Diagnostic Tests and Examinations

1. Radiographs of wrist
2. Electromyogram and nerve conduction studies
3. Hematologic, serologic, and endocrinologic studies if symptoms suggest an underlying systemic disease
4. Response to steroid injection into carpal canal
5. Anteroposterior and lateral oblique radiographs of cervical spine if symptoms suggest origin in the cervical spine
6. Chest radiograph, if there is concern about brachial plexus or apex of lung

C. Evolving Diagnostic Tests and Examinations

1. Carpal tunnel pressure measurements
2. Measurement of sensibility and vibration perception

D. Supporting Evidence

The electromyographic and nerve conduction tests are helpful when positive but can be negative in some patients with this disorder. They are useful in atypical patients or in patients in whom secondary gain may be a motive. The most difficult differentiation involves patients with diabetes mellitus and suspected carpal tunnel syndrome. Some patients with neuropathies may be difficult to assess. Electrodiagnostic studies may facilitate the assessment of patients with both neuropathy and suspected carpal tunnel syndrome. In patients with suspected double-crush syndrome, electrodiagnostic tests may be helpful in determining the relative contributions of each site of compression.

III. Treatment

A. Outpatient Treatment

1. Nonoperative Treatment
   a. Indications
      1) Mild symptoms
      2) Pregnancy
      3) If constricting bindings or positional abnormalities are causative
   b. Treatment Options
      1) Neutral position wrist splint, especially at night
      2) Steroid injections
      3) Diuretic agents
      4) Nonsteroidal anti-inflammatory drugs
      5) Activity modification
      6) Treatment of underlying systemic disease
      7) Removal of constricting bindings or bandages
   c. Rehabilitation
      1) Hand and wrist exercises
      2) Grip strengthening exercises
      3) Modification of activities of daily living and job
   d) Supporting evidence consists of favorable response to steroid injections and to the use of a wrist splint in the absence of objective evidence of denervation

GUIDELINE NUMBER 2 - CARPAL TUNNEL RELEASE

I. Background

Carpal Tunnel Syndrome, also known as tardy median nerve palsy, is believed to be caused by local impairment of the median nerve at the carpal canal in the wrist secondary to narrowing or crowding of the nerve in the carpal tunnel. The condition may have multiple causes including 1) space-occupying lesions such as the residual of a wrist fracture, infections, local edema, tumors, flexor tenosynovitis (non-specific as well as that associated with rheumatoid arthritis), foreign bodies, or aberrant muscles; 2) systemic conditions such as pregnancy, obesity, diabetes mellitus, thyroid dysfunction, arthritis, or amyloidosis; 3) overuse of hand and wrist, work-related trauma and repetitive movements, constricting bandages around the wrist, or improper postural habits regarding the wrist joint; or 4) it may have a spontaneous or idiopathic onset. The condition can occur at any age but it most often encountered in patients over 30 years in age. It occurs three to five times more frequently in women than men.

II. Diagnostic Criteria

A. Pertinent Historical and Physical Findings

Patients complain of paresthesias and numbness in all or part of the sensory distribution pattern of the median nerve in the hand, which often worsen at night when lying in bed. These sensations are occasionally associated with pain that may radiate proximally to the shoulder area. The most characteristic history involves nocturnal paresthesias, described frequently as sensations of burning or numbness that may be relived by shaking or holding the affected arm in the dependent position. Weakness of grip, hypohidrosis, clumsiness and proximal pain migration may be accompanying complaints. Wrist palmar flexion may aggravate the symptoms, and the patient may note difficulty manipulating small objects. Occasionally, patients may complain of circulatory disturbances in the fingers.

Symptoms may be reproduced by hand and wrist motions, such as forced flexion and extension of the wrist, that constrict the carpal canal. This tendency forms the physiologic basis for the Phalen test, which may be positive in the presence of median nerve compression at the wrist. The patient may exhibit dryness of the skin on the hand and fingers, thenar muscle atrophy of fasciculations, and decreased pinch or grip strength. There may be increased median nerve two-point discrimination. Tinel's sign may be positive. These tests are strongly corroborative, but their absence does not exclude this diagnosis.

B. Appropriate Diagnostic Tests and Examinations

1. Radiographs of wrist
2. Electromyogram and nerve conduction studies
3. Hematologic, serologic, and endocrinologic studies if symptoms suggest an underlying systemic disease
4. Response to steroid injection into carpal canal
5. Anteroposterior and lateral oblique radiographs of cervical spine if symptoms suggest origin in the cervical spine
6. Chest radiograph, if there is concern about brachial plexus or apex of lung

C. Evolving Diagnostic Tests and Examinations

1. Carpal tunnel pressure measurements
2. Measurement of sensibility and vibration perception

D. Supporting Evidence

The electromyographic and nerve conduction tests are helpful when positive but can be negative in some patients with this disorder. They are useful in atypical patients or in patients in whom secondary gain may be a motive. The most difficult differentiation involves patients with diabetes mellitus and suspected carpal tunnel syndrome. Some patients with neuropathies may be difficult to assess. Electrodiagnostic studies may facilitate the assessment of patients with both neuropathy and suspected carpal tunnel syndrome. In patients with suspected double-crush syndrome, electrodiagnostic tests may be helpful in determining the relative contributions of each site of compression.

III. Treatment

A. Outpatient Treatment

1. Ambulatory Surgery
   a. Indications
      1) Failure to respond to nonoperative treatment
      2) Presence of thenar atrophy or weakness or significant hyperesthesia/dysesthesia (especially with objective impairment of sensibility as determined by two-point discrimination or by light touch)
      3) Progressive symptoms
      4) Presence of space-occupying lesion in carpal canal
   b. Treatment options
      1) Release of transverse carpal ligament, either under local or regional block, or general anesthesia
      2) Tenosynovectomy at the wrist
      3) Opponensplasty
   c. Home health care may be necessary in selected care such as in opposite-hand dysfunction
   d. Rehabilitation
      1) Elevation of hand and exercise of fingers and shoulder
      2) Wrist splint in position of slight extension to three weeks postoperatively
   e. Supporting Evidence
      Carpal tunnel release may provide partial or complete relief of symptoms in over 85% of patients. Pain is relieved more often than numbness, particularly in older patients with severe numbness or in those patients with associated diabetes mellitus. Patients who have sustained worker's compensation related injuries or patients with diabetes mellitus seem to be more refractory to treatment efforts. Complications are not frequent, but prolonged tenderness in the region of the surgical incision is not unusual.

f. Controversial treatment
   1) Median nerve internal neurolysis
   2) Concurrent routine release of the ulnar nerve at Guyon's canal
   3) Flexor tenosynovectomy

B. Inpatient Treatment

1. Nonoperative inpatient treatment is not indicated
2. Operative treatment
   a. Indications for Admission
      1) Bilateral surgical release
      2) Impaired function in opposite upper extremity
      3) Concurrent systemic disease increasing surgical risk
      4) Presence of compartment syndrome or extensive injury to the forearm and wrist
   b. Treatment Options
      1) Release of transverse carpal ligament, either under local or regional block, or general anesthesia
      2) External or internal neurolysis of median nerve and/or its branches
      3) Tenosynovectomy at the wrist
      4) Opponensplasty
   c, Indications for discharge
      1) Uncomplicated cases in which the patient's medical condition is stable and the patient is comfortable, usually one to three days postoperatively
      2) Complicated
         a) Resolved wound complication
         b) Medical instability of patient well-controlled
   d. Home Health Care: same as III,A,1,c
   e. Rehabilitation: same as III,A,1,d

C. Estimated Duration of Care

1. Nonoperative treatment - two to three months
2. Operative treatment - two to six months
   (Note: These periods will be longer in patients with severe preoperative numbness or significant thenaratrophy.)

D. Anticipated Outcomes

1. Pain reduction
2. Improvement of sensation and/or motor function
3. Reduction of paresthesias (note: in come elderly patients or those with severe preoperative compression, postoperative dysesthesias may be associated with the recovering preoperative neuropraxia.)
4. Improved dexterity and grip strength

5. Improved vasomotor function
6. Prevention of further deterioration in nerve function

E. Evolving Therapeutic Procedures

1. Ergometric studies to improve workplace situations
2. Arthroscopic release

F. Modifiers (age, sex, and co-morbidity)

Pregnant women may have a transitory carpal tunnel syndrome that usually resolves itself after delivery. Occasionally, a pregnant patient may prove refractory to non-operative treatment. Persisting symptoms may be severe enough to require surgical release of the carpal canal during the pregnancy or after delivery.

GUIDELINE NUMBER 3 - THORACIC OUTLET SYNDROME VASCULAR ORIGIN - VENOUS

I. Conservative Care

Not Applicable

II. Clinical Findings

A. Subjective

At least three of the following must be present in the affected upper extremity:

1. Pain
2. Swelling or heaviness
3. Decreased temperature or change in color
4. Paresthesias in the ulnar nerve distribution

AND

B. Objective

For Venous TOS: at least two of the following:

1. Swelling or venous engorgement
2. Cyanosis
3. Dilation of veins
4. Abnormal venogram or plethysmography

C. Imaging

Not Applicable

GUIDELINE NUMBER 4 - THORACIC OUTLET SYNDROME VASCULAR ORIGIN - ARTERIAL

I. Conservative Care

Not Applicable

II. Clinical Findings

A. Subjective

At least three of the following must be present in the affected upper extremity:

1. Pain
2. Swelling or heaviness
3. Decreased temperature or change in color
4. Paresthesias in the ulnar nerve distribution

AND

B. Objective

For Arterial TOS: at least two of the following:

1. Pallor or coolness
2. Abnormal arteriogram or doppler ultrasonography
3. Gangrene of the digits in advance cases

C. Imaging

Not Applicable

GUIDELINE NUMBER 5 - THORACIC OUTLET SYNDROME NEUROGENIC ORIGIN

I. Conservative Care

A. 3 months of conservative treatment; and
B. A second surgical opinion from a non-surgical specialist (e.g., neurologist, physiatrist, or rheumatologist)

AND

II. Clinical Findings

A. Subjective

In the affected upper extremities:

1. Pain; and
2. Numbness or paresthesias in the ulnar nerve distribution; and
3. At least two of the following tests must exactly reproduce symptoms of pain with or without pulse obliteration (in the affected upper extremity):
   a) Roos' maneuver
   b) Adson's maneuver
   c) Costoclavicular maneuver
   d) Hyperabduction maneuver

AND

B. Objective

In the affected upper extremity:

1. Positive doppler ultrasonography; or
2. Positive nerve conduction, EMG or somatosensory evoked potential studies

OR

C. Imaging

1. X-ray studies that confirm the presence of cervical ribs, elongated C-7 process, hypoplastic first rib or fractured clavicle.

Special Instructions
A psychiatric or psychological evaluation may be required on a case-specific basis.

GUIDELINE NUMBER 6 - ROTATOR CUFF REPAIR SHOULDER

I. Conservative Care

A. Failure to improve with outpatient therapy and conservative care for the following time periods:

1. Acute case: 1 to 3 weeks; or
2. Erosive case: 3 to 6 months*

*Three months of conservative care is adequate if treatment has been continuous; six months applies to those cases in which treatment has been intermittent.

AND

II. Clinical Findings

A. Subjective

1. Severe shoulder pain and inability to raise shoulder

AND

B. Objective

1. Weak or absent abduction; and
2. Tenderness over rotator cuff; and/or
3. Pain relief obtained with an injection of anesthetic for diagnostic/therapeutic trial

AND

C. Imaging

1. Positive findings on arthrogram, MRI, or ultrasound; or
2. Positive findings on previous arthroscopy, if performed

Special Instructions
Cervical pathology and frozen shoulder syndrome should be ruled out prior to the request.

GUIDELINE NUMBER 7 - ANTERIOR ACROMIONECTOMY FOR ACROMIAL IMPINGEMENT SYNDROME SHOULDER

I. Conservative Care

A. Failure to improve with 4-6 months of conservative care

AND

II. Clinical Findings

A. Subjective

1. Pain with active arc motion 90 to 130 degrees; **and**
2. Pain at night

AND

B. Objective

1. Positive impingement test and relief of pain with anesthetic injection (Tenderness in the anterior acromial area may also be present)

AND

C. Imaging

Suggested:

1. X-ray of coraco-acromial to document status of bony arch

GUIDELINE NUMBER 8 - REPAIR OF AC OR CC LIGAMENTS ACROMIO-CLAVICULAR SEPARATION SHOULDER

I. Conservative Care

A. Applicable to those separations that cannot be reduced and held in a brace; or
B. Failure to improve after 1 week trial period in support brace

AND

II. Clinical Findings

A. Subjective

1. Localized pain at AC joint

AND

B. Objective

1. Prominent distal clavicle

AND

C. Imaging

1. Separation at AC joint with weight-bearing films

GUIDELINE NUMBER 9 - MUMFORD PROCEDURE
ACROMIO-CLAVICULAR SEPARATION
SHOULDER

I. Conservative Care

A. Failure to improve within 30-60 days of conservative care

AND

II. Clinical Findings

A. Subjective

1. Pain at AC joint; aggravation of pain with motion of shoulder or carrying weight

AND

B. Objective

1. Confirmation that separation of AC joint is unresolved; **and**
2. Prominent distal clavicle; **and/or**
3. Pain relief obtained with an injection of anesthetic for diagnostic/therapeutic trial

AND

C. Imaging

1. Separation of AC joint with weight-bearing films; **or**
2. Severe DJD at AC joint noted on x-rays

GUIDELINE NUMBER 10 - OPEN BANKART OR BRISTOW FOR RECURRENT DISLOCATION SHOULDER

I. Conservative Care

None

II. Clinical Findings

A. Subjective

A. History of multiple dislocation that inhibit activities of daily living

AND

B. Objective

None

C. Imaging

Suggested:

1. X-ray to either confirm dislocation or exclude fracture or other bony abnormalities

Special Instructions

A second surgical opinion and psychiatric/psychological evaluation will be obtained if this is the second request for this procedure.

GUIDELINE NUMBER 11 - REPAIR OF BICEPS TENDON PROXIMAL RUPTURE OF THE BICEPS SHOULDER

I. Conservative Care

None

II. Clinical Findings

A. Subjective

1. Complaint of more than "normal" amount of pain that does not resolve with attempt to use arm

AND

B. Objective

1. Palpation of "bulge" in upper aspect of arm

C. Imaging

None

Special Instructions

1. *90% do not need repair.*
2. *Consideration of the tenodesis should include the following:*
   - *a) Patient should be a young adult*
   - *b) Procedure should be done in conjunction with another open repair*
   - *c) There should be evidence of an incomplete tear*

GUIDELINE NUMBER 12 - REPAIR OF BICEPS TENDON DISTAL RUPTURE OF THE BICEPS SHOULDER

I. Conservative Care

None

II. Clinical Findings

A. Subjective

1. Pain

AND

B. Objective

1. Inability of physician to palpate the insertion of the tendon at the patient's antecubital fossa

AND

C. Imaging

None

Special Instructions
All should be repaired within one week of injury or diagnosis.

GUIDELINE NUMBER 13 - SHOULDER ARTHROSCOPY FOR DIAGNOSTIC PURPOSES SHOULDER

I. Conservative Care

None

II. Clinical Findings

A. Subjective

1. Acute pain; or
2. Limitation of function despite conservative treatment

AND

B. Objective

1. Diminution of function

AND

C. Imaging

Inconclusive

Special Instructions

This procedure is used primarily for diagnostic purposes when other imaging is inconclusive and acute pain or limitation of function continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. Request for authorization for this procedure in the inpatient setting will be reviewed by a peer physician.

GUIDELINE NUMBER 14 - ANTERIOR CRUCIATE LIGAMENT (ACL) REPAIR KNEE

I. Conservative Care

Not Applicable

II. Clinical Findings

A. Subjective

(Pain alone is not an indication)

1. Instability of the knee; described as "buckling or giving way"; **and**
   a) Significant effusion at time of injury; **and/or**
   b) Description of injury indicates a rotary twisting or hyperextension occurred

AND

B. Objective

1. Positive Lachman's sign;

Supportive findings:

a) Positive pivot shift; **and/or**
b) Positive anterior drawer; **and/or**
c) Positive KT 1000, > 3-5 mm = +1
   > 5-7 mm = +2
   > 7 mm = +3

AND

C. Imaging

Positive findings with:

1. Arthrogram; **or**
2. MRI; **or**
3. Arthroscopy

GUIDELINE NUMBER 15 - PATELLA TENDON RE-ALIGNMENT MAQUET PROCEDURE KNEE

I. Conservative Care

Not Applicable

II. Clinical Findings

A. Subjective

1. Rest-sitting pain

AND

B. Objective

1. Pain with patellar/femoral movement; **and/or**
2. Recurrent dislocations

AND

C. Imaging

1. Recurrent effusion; **and**
2. Patella apprehension; **and**
3. Synovitis with or without crepitus; **and**
4. Lateral tracking; **and**
5. Increased Q angle > 15 degrees

GUIDELINE NUMBER 16 - KNEE JOINT REPLACEMENT

I. Conservative Care

Not Applicable

II. Clinical Findings

A. Subjective

1. Limited range of motion; **and**
2. Night pain of the joint; **and**
3. No relief of pain with conservative care

AND

B. Objective

1. Significant loss or erosion of cartilage to the bone

AND

C. Imaging

Positive findings with:

1. Standing films; **or**
2. Arthroscopy

Special Instructions

If 2 or 3 compartments are affected, a total replacement is indicated. If only 1 compartment is affected, a unicompartmental or partial replacement is indicated.)

GUIDELINE NUMBER 17 - LATERAL LIGAMENT ANKLE RECONSTRUCTION FOR CHRONIC INSTABILITY OF ANKLE

I. Conservative Care

A. Physical Therapy
   1. Immobilization with support cast or ankle brace

B. Rehab Program

For either of the above, time frame will be variable with severity of trauma

AND

II. Clinical Findings

A. Subjective

   1. Instability of the ankle;

   Supportive findings:

   1. Complaint of swelling

AND

B. Objective

   1. Positive anterior drawer

AND

C. Imaging

   1. Positive stress x-rays identifying motion at ankle or subtalar joint. At least 15° lateral opening at the ankle joint; or
   2. Demonstrable subtalar movement; and
   3. Negative to minimal arthritic joint changes on x-ray

GUIDELINE NUMBER 18 - LATERAL LIGAMENT ANKLE RECONSTRUCTION FOR ACUTE ANKLE SPRAIN/STRAIN INVERSION INJURY

I. Conservative Care

A. Physical Therapy
   1. Immobilization with support cast or ankle brace

B. Rehab Program

For either of the above, time frame will be variable with severity of trauma

AND

II. Clinical Findings

A. Subjective

1. Description of an inversion; and/or
2. Hyperextension injury, ecchymosis, swelling

B. Objective

1. Grade 3 injury (lateral injury); and/or
2. Osteochondral fragment; and/or
3. Medial incompetence; and
4. Positive anterior drawer

C. Imaging

1. Positive stress x-rays identifying motion at ankle or subtalar joint. At least 15° lateral opening at the ankle joint; or
2. Demonstrable subtalar movement; and
3. Negative to minimal arthritic joint changes on x-ray

GUIDELINE NUMBER 19 - FUSION ANKLE-TARSAL-METATARSAL TO TREAT NON-UNION OR MALUNION OF A FRACTURE OR TRAUMATIC ARTHRITIS SECONDARY TO ON THE JOB INJURY TO THE AFFECTED JOINT

I. Conservative Care

Immobilization which may include:

A. Casting, bracing, shoe modification or other orthotics; **or**
B. Anti-inflammatory medications

AND

II. Clinical Findings

A. Subjective

1. Pain including that which is aggravated by activity and weight-bearing; **and**
2. Relieved by Xylocaine injection

AND

B. Objective

1. Malalignment; **and**
2. Decreased range of motion

AND

C. Imaging

Positive x-ray confirming presence of:

1. Loss of articular cartilage (arthritis); **or**
2. Bone deformity (hypertrophic spurring, sclerosis); **or**
3. Non or mal-union of a fracture

Special Instructions

Supportive imaging could include: Bone Scan (for arthritis only) to confirm localization, or MRI, or Tomography.

GUIDELINE NUMBER 20 - CONSERVATIVE OUTPATIENT DIAGNOSIS AND TREATMENT OF NECK AND BACK INJURIES ACUTE - UP TO 6 WEEKS FROM DATE OF INJURY UTILIZATION GUIDELINE

Background:

Low back injuries are a common cause of pain in the general population and are often the result of the functional demands placed on the low back or neck area by every day activities. The diagnosis is not known in 80-90% of cases and pain may include the leg or arm as well as the back or neck. For the vast majority of patients, the discomfort is of short duration and complete recovery is the general rule.

This guideline is meant to cover the usage of the vast majority of tests and treatments, but it is expected that approximately 10% of cases will fall outside this guideline and thus require review. It is expected that a strong majority of these outliers should be accepted as management within acceptable, although not average, standards of care.

Exclusions: (Individuals with a back or neck pain with any one of the following are excluded from this guideline and will be considered in another.)

Physical Findings:

Objective neurological impairment and/or nerve root tension signs on physical examination with increasing arm or leg pain.

History Of:

(If patient history reveals any of the following conditions, this guideline would not apply.)

- Concurrent unexplained fever over 48 hours
- Neoplasm
- Severe trauma
- Specific diagnoses (rheumatoid arthritis, herniated sick, spinal stenosis, spondylolisthesis, congenital fusion, diastematomyelia, hemivertebra, spinal osteomyelitis, prior back surgery)
- Bowel and bladder symptoms

Other

- Age over 50

Acute Diagnostic and Treatment Measures: (Up to 6 weeks from date of injury)

Diagnostic Tests:

X-rays: (Only one examination allowed)
Back - Maximum 4 views
Neck - Maximum 5 views

CT, MRI, Bone Scan - Not allowed under this guideline

Computer Back Testing (CBT) - Not allowed under this guideline

EMG and Nerve Conduction - Not allowed under this guideline

Functional Capacity Testing (FCT) - Not allowed under this guideline

Work Capacity Evaluation (WCE) - Not allowed under this guideline

Thermogram - Not allowed under this guideline

Myelogram - Not allowed under this guideline

Inpatient Treatment - Not allowed under this guideline

Outpatient Treatment - (Within scope of license):

Medical office treatment sessions maximum 4 visits in first 6 weeks

Physical therapy treatment sessions maximum 18 visits in first 6 weeks

Occupational therapy treatment sessions maximum 6 visits in first 6 weeks

Chiropractic treatment sessions maximum 18 visits in first 6 weeks

Bedrest: 0 to 4 days maximum

Non-narcotic analgesics: Muscle relaxants, nonsteroidal anti-inflammatory drugs - No limit but prescribed by one practitioner

Narcotics - Not allowed after 5 days from injury and prescribed by only one practitioner

Restricted activity - until functional recovery up to 0 to 6 weeks

Trigger point injection - maximum of 2 within 4 weeks

Facet injection - Not allowed under this guideline

Epidural block - not allowed under this guideline

Lumbar support - Allowed

Cervical collar - Allowed

Traction (Back) - Not allowed under this guideline

Traction (Neck) - Allowed

TENS - Not allowed under this guideline for home use

Serious consideration for referral by physician or employer for chiropractic or physical or occupational therapy

Physical agents (heat/cold, electrical stimulation, biofeedback, iontophoresis/phonophoresis, ultrasound, fluori-methane) maximum of 2 allowed per treatment session - Not allowed if only treatment

Manual therapy/spinal adjustment/manipulation - Allowed

Therapeutic or aquatic exercise - Allowed

Patient education and activities of daily living, joint protection techniques, and back pain recovery and prevention - Allowed

(For patients treated by more than one discipline (physical therapy, occupational therapy, allopathic medicine, and chiropractic), similar services should not be duplicated.)

GUIDELINE NUMBER 21 - CONSERVATIVE OUTPATIENT DIAGNOSIS AND TREATMENT OF NECK AND BACK INJURIES SUB-ACUTE - FROM 7 TO 12 WEEKS FROM DATE OF INJURY UTILIZATION GUIDELINE

Background:

Low back injuries are a common cause of pain in the general population and are often the result of the functional demands placed on the low back or neck area by every day activities. The diagnosis is not known in 80-90% of cases and pain may include the leg or arm as well as the back or neck. For the vast majority of patients, the discomfort is of short duration and complete recovery is the general rule.

This guideline is meant to cover the usage of the vast majority of tests and treatments, but it is expected that approximately 10% of cases will fall outside this guideline and thus require review. It is expected that a strong majority of these outliers should be accepted as management within acceptable, although not average, standards of care.

Exclusions: (Individuals with a back or neck pain with any one of the following are excluded from this guideline and will be considered in another.)

Physical Findings:

Objective neurological impairment and/or nerve root tension signs on physical examination with increasing arm or leg pain.

History Of:

(If patient history reveals any of the following conditions, this guideline would not apply.)

- Concurrent unexplained fever over 48 hours
- Neoplasm
- Severe trauma
- Specific diagnoses (rheumatoid arthritis, herniated sick, spinal stenosis, spondylolisthesis, congenital fusion, diastematomyelia, hemivertebra, spinal osteomyelitis, prior back surgery)
- Bowel and bladder symptoms

Other

- Age over 50

Subacute Diagnostic and Treatment Measures: (From 7-12 weeks from date of injury)

Under the following patient conditions, diagnostic tests and treatment measures, as specified above, may be used and care may need to extend beyond the first 6 weeks from the time of injury. However, the total time of care should not continue for a duration of longer than 12 weeks from the time of injury:

- Back to work full time with persistent symptoms
- Severe symptoms over 2 weeks without treatment
- Severe symptoms unimproved over 3 weeks with treatment
- Heavy smoking
- Chemical dependency
- Emotional distress documented by psychologic evaluation or physical findings (hysterical or Waddell signs)
- Over 3 prior attacks of back pain
- Heavy lifting (50 pounds) or constant sitting job
- Pregnancy (over 5 months)
- Sacralization, asymmetric facet, segmental instability

Diagnostic Tests: (7-12 weeks from date of injury)

- Bone Scan - Not allowed under this guideline
- EMG - Not allowed under this guideline
- Thermogram - Not allowed under this guideline
- Myelogram - Not allowed under this guideline

Inpatient treatment: Not allowed under this guideline

Outpatient treatment: (Within scope of license)

Medical office treatment sessions maximum 2 visits between weeks 7 and 12

OT Rx sessions 10 visits between weeks 7 and 12

Physical therapy treatment sessions maximum 10 visits between weeks 7 and 12

Chiropractic treatment sessions maximum 10 visits between weeks 7 and 12

Scheduled medication not allowed under this guideline

Non-narcotic analgesics, muscle relaxants, non-steroidal anti-inflammatory agents - Allowed but de-emphasized

Activity - formal employer contact for transitional/modified work availability - Encouraged

TENS - Not allowed under this guideline for home use

Traction (Back) - Not allowed under this guideline

Traction (Neck) - Allowed under this guideline

Trigger point injection - Maximum of one in weeks between 7 and 12

Rehabilitation referral (education, aerobic and job specific exercises, vocational rehabilitation, functional capacity test) - Allowed

Physical agents (heat/cold, electrical stimulation, biofeedback, iontophoresis/phonophoresis, ultrasound, flouri-methane) maximum of 1 allowed per treatment session - Not allowed if only treatment - generally de-emphasized

Manual therapy/spinal adjustment/manipulation - Allowed

Therapeutic or aquatic exercises - Encouraged

Patient education and activities of daily living, joint protection techniques, and back pain recovery and prevention - Encouraged

(For patients treated by more than one discipline (physical therapy, occupational therapy, allopathic medicine, and chiropractic), similar services should not be duplicated.)

Chronic Diagnostic and Treatment Measures: (Over 12 weeks from date of injury)

Independent medical evaluation by provider of same specialty for determination of maximal medical improvement

Patients should enter chronic pain guideline

GUIDELINE NUMBER 22 - SURGERY FOR CERVICAL RADICULOPATHY FOR ENTRAPMENT OF A SINGLE NERVE ROOT

I. Conservative Care

A. 6-8 weeks minimum

For example:
physical therapy
non-steroid anti-inflammatory agents
cervical traction

AND

II. Clinical Findings

A. Subjective

1. Sensory symptoms in a dermatomal distribution (could include: radiating pain, paraesthesia, tingling, burning, or numbness)

AND

B. Objective

1. Dermatomal sensory deficit; **or**
2. Motor deficit; **or**
3. Reflex changes; **or**
4. Positive EMG

AND

C. Imaging

1. Abnormal test results that correlate with the level of nerve root involvement consistent with subjective and objective findings. Tests could include CT scan, MRI, or Myelogram.

Special Instructions

1. Cases to be referred to a physician advisor:
   a. Repeat surgery at same level
   b. Request for surgery at the C#-4 level
   c. Requests for surgery with signs and symptoms indicating myelopathy
2. When requesting authorization for decompression of multiple level nerve roots, each level is subject to the criteria.

GUIDELINE NUMBER 23 - DIAGNOSIS AND OUTPATIENT TREATMENT OF A SINGLE LUMBAR SPINAL NERVE ROOT ENTRAPMENT

Background:

Compression of a lumbar nerve root causes inflammation, vascular compromise, and leg pain. Causes include disk herniation, burst fractures or fracture dislocations, spondylolisthesis or other malalignments, congenital or degenerative narrowing of the spinal canal or foramina, and abnormal bone formation after spinal fusion or with Paget's disease or fluorosis.

This guideline is meant to cover the usage of a vast majority of tests and treatments, but it is expected that approximately 10% of cases will fall outside this guideline and thus require a review. It is expected that a strong majority of these outliers should be accepted as management within acceptable, although not average, standards of care.

Diagnostic Criteria:

Symptoms:

Radicular pain (sharp, shooting) within nerve root distribution with or without back pain

Weakness or sensory disturbance in limb

Objective Physical Findings: (One required to be positive in order to proceed with diagnostic tests)

Atrophy of calf or thigh

Segmental motor loss

Femoral stretch test positive

Knee or ankle reflex (including posterior tibial) decrease

Sensory loss in distribution of nerve root pattern

Positive straight or reversed straight leg raising producing leg pain confirmed in 2 anatomic positions (sitting and supine)

Appropriate Diagnostic Test: (Maximum of 3 if results negative)

Low back x-rays if not done since injury

CT scan

MRI

Myelogram/CT

Bone scan (not as only diagnostic test)

EMG (not as sole diagnostic test or under 21 days from onset of symptoms)

Laboratory testing if metabolic or oncologic diagnosis suspected

Not allowed under this guideline:

Myeloscopy

Discography

Somatosensory evoked potentials

Thermography

Evoked potentials

Outpatient Treatment: (Within scope of license)

Non-operative: (Maximum duration of care 6 months from date of injury)

Narcotic medication (not over 6 weeks duration in treatment)

Epidural steroid injection (maximum 3)

Physician office treatment sessions maximum 12 visits

Physical therapy treatment sessions maximum 42 visits

Occupational therapy treatment sessions maximum 6 visits

Chiropractic treatment sessions maximum 42 visits

Non-narcotic analgesics, muscle relaxants, nonsteroidal anti-inflammatory drugs - No limit

Encourage communication regarding transitional/modified work availability

Facet injection - Allowed (maximum of 3)

Lumbar support - Allowed

Serious consideration for referral by physician or employer for chiropractic or physical or occupational therapy

Physical agents (heat/cold, electrical stimulation, traction, biofeedback, iontophoresis/phonophoresis, ultrasound, fluori-methane) maximum of 2 allowed per treatment session - Not allowed if only treatment

Manual therapy/spinal adjustment/manipulation - Allowed

Rehabilitation referral (education, aerobic and job specific exercise, functional capacity test) - Allowed

Patient education and activities of daily living, joint protection techniques, and back pain recovery and prevention - Allowed

(For patients treated by more than one discipline (physical therapy, occupational therapy, allopathic medicine, and chiropractic, similar services should not be duplicated.)

GUIDELINE NUMBER 24 - OPERATIVE TREATMENT OF A SINGLE LUMBAR SPINAL NERVE ROOT ENTRAPMENT

Background:

Compression of a lumbar nerve root causes inflammation, vascular compromise, and leg pain. Causes include disk herniation, burst fractures or fracture dislocations, spondylolisthesis or other malalignments, congenital or degenerative narrowing of the spinal canal or foramina, and abnormal bone formation after spinal fusion or with Paget's disease or fluorosis.

This guideline is meant to cover the usage of a vast majority of tests and treatments, but it is expected that approximately 10% of cases will fall outside this guideline and thus require a review. It is expected that a strong majority of these outliers should be accepted as management within acceptable, although not average, standards of care.

Diagnostic Criteria:

Symptoms:

Radicular pain (sharp, shooting) within nerve root distribution with or without back pain

Weakness or sensory disturbance in limb

Objective Physical Findings: (One required to be positive in order to proceed with diagnostic tests)

Atrophy of calf or thigh

Segmental motor loss

Femoral stretch test positive

Knee or ankle reflex (including posterior tibial) decrease

Sensory loss in distribution of nerve root pattern

Positive straight or reversed straight leg raising producing leg pain confirmed in 2 anatomic positions (sitting and supine)

Appropriate Diagnostic Test: (Maximum of 3 if results negative)

Low back x-rays if not done since injury

CT scan

MRI

Myelogram/CT

Bone scan (not as only diagnostic test)

EMG (not as sole diagnostic test or under 21 days from onset of symptoms)

Laboratory testing if metabolic or oncologic diagnosis suspected

Not allowed under this guideline:

Myeloscopy

Discography

Somatosensory evoked potentials

Thermography

Evoked potentials

Inpatient Treatment:

Operative Care:

Surgical Options:

Laminectomy, Laminotomy, Diskectomy, Micro-diskectomy, Foraminotomy, Foraminal decompression, Spinal fusion (percutaneous diskectomy, chemonucleolysis, and spinal fusion without decompressive laminectomy - not allowed)

Indications: (All must be present)

Radiating (radicular) leg pain greater than back pain

Objective evidence of significant or progressive neurologic deficit in the distribution of a single spinal nerve as indicated by any one of the following objective signs:

a. Motor deficit (e.g., foot drop or quadriceps weakness)
b. Sensory deficit
c. Reflex changes
d. Positive EMG

Documented (MRI, CT scan or myelogram) evidence of nerve root compression

Length of Stay: 0-5 days post-operative - (7 days for spinal fusion)

Physical Therapy: Allowed

Indications for Discharge:

No complication requiring hospitalization (wound infection, spinal fluid leak, DVT, etc.)

Ambulatory status consistent with home care (home health care may be needed)

Post Hospital Treatment:

Maximum duration of recovery 4 months from time of surgery (1 year for spinal fusion)

Office visits - 5 in first 4 months

Physical therapy treatment session maximum 24 visits

Chiropractic treatment sessions maximum 24 visits

Occupational therapy maximum 6 visits

Non-narcotic analgesics, muscle relaxants, non-steroidal anti-inflammatory agents - Allowed

Activity - formal employer contact for transitional modified work availability _ Encouraged

Rehabilitation referral (education, aerobic and job specific exercises, vocational rehabilitation, functional capacity test) - Allowed

Physical agents (heat.cold, electrical stimulation, biofeedback, iontophoresis/phonophoresis, ultrasound, flouri-methane) maximum of 1 allowed per treatment session - Not allowed if only treatment - generally de-emphasized

Therapeutic and aquatic exercises - Encouraged

Patient education and activities of daily living, joint protection techniques, and back pain recovery and prevention - Encouraged

Vocational rehabilitation - Allowed

(For patients treated by more than one discipline (physical therapy, occupational therapy, allopathic medicine, and chiropractic), similar services should not be duplicate.)

GUIDELINE NUMBER 25 - CAUDA EQUINA SYNDROME

I. Conservative Care

Not Applicable

II. Clinical Findings

A. Subjective

1. Sudden onset or rapid progression of sensory symptoms

AND

B. Objective

1. Acute progressive neurological deficit that is either bilateral or involves multiple neurological levels

AND

C. Imaging

1. Demonstrates a large lesion producing central stenosis with tight obstruction. Test include: CT Scan, or MRI, or Myelogram

This screening criteria is used to evaluate requests for surgical intervention to treat Cauda Equina Syndrome. In the event a worker experiences a sudden onset, or rapid progression of symptoms, surgery should not be delayed if the physician believes that such a delay will jeopardize the patient's health and safety or compromise the results of surgery.

Criteria for Authorizing Surgery

Surgery for Cauda Equina Syndrome will be authorized if both of the following conditions are met.

1. Myelogram, MRI, or CT scan showing a large lesion producing central stenosis of the spinal canal with tight obstruction

AND

2. Acute progressive neurological deficit that is either bilateral or involves multiple neurological levels.

SECTION 6:

REVIEW CRITERIA

EFFECTIVE JULY 1, 1993

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA LIST

Criteria Number 1	Carpal Tunnel Syndrome Conservative Non-Operative Treatment
Criteria Number 2	Carpal Tunnel Release
Criteria Number 3	Thoracic Outlet Syndrome Vascular Origin - Venous
Criteria Number 4	Thoracic Outlet Syndrome Vascular Origin - Arterial
Criteria Number 5	Thoracic Outlet Syndrome Neurogenic Origin
Criteria Number 6	Rotator Cuff Repair Shoulder
Criteria Number 7	Anterior Acromionectomy for Acromial Impingement Syndrome Shoulder
Criteria Number 8	Repair of AC or CC Ligaments Acromio-Clavicular Separation Shoulder
Criteria Number 9	Mumford Procedure Acromio-Clavicular Separation Shoulder
Criteria Number 10	Open Bankart or Bristow for Recurrent Dislocation Shoulder
Criteria Number 11	Repair of Biceps Tendon Proximal Rupture of the Biceps Shoulder
Criteria Number 12	Repair of Biceps Tendon Distal Rupture of the Biceps Shoulder
Criteria Number 13	Shoulder Arthroscopy for Diagnostic Purposes Shoulder
Criteria Number 14	Anterior Cruciate Ligament (ACL) Repair Knee
Criteria Number 15	Patella Tendon Re-Alignment Maquet Procedure Knee

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Criteria List

COMMONWEALTH OF MASSACHUSETTS
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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 1 - CARPAL TUNNEL SYNDROME
CONSERVATIVE NON-OPERATIVE TREATMENT

NARRATIVE DESCRIPTION

Carpal Tunnel Syndrome

I. History/Symptoms

Must meet one of the following:

A. Paresthesias (pricking, tingling, or numbness) in the median nerve distribution of the hand; or
B. Weakness of grip

AND

II. Physical Findings

Must meet one of the following:

A. Positive Tinels test; or
B. Positive Phalen test

OR

III. Diagnostic Testing

Must meet one of the following:

A. Positive electromyograph; or
B. Positive nerve conduction studies

IV. Treatment Measures

A. Hand and wrist exercise program for rehabilitation; and/or
B. Neutral position wrist splint; and/or
C. Steroid injection; and/or
D. Nonsteroidal anti-inflammatory drugs; and/or
E. Activity modification

Special Instructions
If symptoms persist or worsen after eight (8) weeks of conservative treatment surgical intervention may be required.

Level of Care Required
Outpatient

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 2 - CARPAL TUNNEL RELEASE

NARRATIVE DESCRIPTION

Release of Carpal Tunnel

I. History/Symptoms

Must meet one of the following:

A. Paresthesias (pricking, tingling, or numbness) in the Median nerve distribution of the hand; **or**
B. Weakness of grip

AND

II. Physical Findings

Must meet one of the following:

A. Positive Tinels test; **or**
B. Positive Phalen test

OR

III. Diagnostic Testing

Not Applicable

IV. Indications for Surgery

A. Failure to respond to nonoperative treatment; **or**
B. Presence of thenar atrophy or weakness or significant hyperesthesia/sysesthesia (especially with objective impairment of sensibility as determined by two-point discrimination or by light touch); **or**
C. Progressive symptoms in the presence of conservative treatment; **or**
D. Presence of space-occupying lesion in carpal canal

Special Instructions
Inpatient if bilateral procedures, or impaired function in the opposite upper extremity, or concurrent systemic disease increasing surgical risk, or the presence of compartment syndrome, or extensive injury to the forearm and wrist.

Level of Care Required
Outpatient

CRITERIA NUMBER 3 - THORACIC OUTLET SYNDROME VASCULAR ORIGIN - VENOUS

NARRATIVE DESCRIPTION

Thoracic Outlet Release - Venous

I. History/Symptoms

Must meet three of the following present in the affected upper extremity

A. Pain; **or**
B. Swelling or heaviness; **or**
C. Decreased temperature or change in color; **or**
D. Paresthesis in the ulnar nerve distribution

AND

II. Physical Findings

Must meet one of the following:

A. Swelling or venous engorgement; **or**
B. Cyanosis; **or**
C. Dilation of veins

AND

III. Diagnostic Testing

Must meet one of the following:

A. Abnormal venogram; **or**
B. Abnormal plethysmography

Special Instructions
None

Level of Care Required
Inpatient

CRITERIA NUMBER 4 - THORACIC OUTLET SYNDROME VASCULAR ORIGIN - ARTERIAL

NARRATIVE DESCRIPTION

Thoracic Outlet Release - Arterial

I. History/Symptoms

Must meet three of the following present in the affected upper extremity

A. Pain; or
B. Swelling or heaviness; or
C. Decreased temperature or change in color; or
D. Paresthesis in the ulnar nerve distribution

AND

II. Physical Findings

Must meet one of the following:

A. Pallor or coolness; or
B. Gangrene of the digits in advanced cases

AND

III. Diagnostic Testing

Must meet one of the following:

A. Abnormal arteriogram; or
B. Abnormal doppler ultrasonography

Special Instructions
None

Level of Care Required
Inpatient

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REVIEW CRITERIA
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CRITERIA NUMBER 5 - THORACIC OUTLET SYNDROME NEUROGENIC ORIGIN

NARRATIVE DESCRIPTION

Thoracic Outlet Release - Neurogenic

I. History/Symptoms

Must meet the following in the affected upper extremities

A. Pain; and
B. Paresthesis (numbness, prickling, in the ulnar nerve distribution - side of forearm opposite thumb

AND

II. Physical Findings

Must meet two of the following test that exactly reproduce symptoms of pain with or without pulse obliteration in the affected upper extremity:

A. Roos maneuver; or
B. Adson's maneuver; or
C. Costoclavicular maneuver; or
D. Hyperabduction maneuver

AND

III. Diagnostic Testing

Positive test findings on one of the following the affected upper extremity:

A. Positive doppler ultrasonography; or
B. Positive nerve conduction studies; or
C. EMG; or
D. Somatosensory evoked potential studies; or
E. X-ray studies that confirm the presence of cervical ribs, elongated C-7 process, hypoplastic first rib, or fractured clavicle.

AND

IV. Failure to improve after three months of conservative treatment; **and**

V. A second surgical opinion is obtained from a non-surgical specialist (e.g., neurologist, physiatrist, or rheumatologist).

Special Instructions
A psychiatrist or psychological evaluation may be required on a case-specific basis.

Level of Care Required
Inpatient

COMMONWEALTH OF MASSACHUSETTS
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REVIEW CRITERIA
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CRITERIA NUMBER 6 - ROTATOR CUFF REPAIR SHOULDER

NARRATIVE DESCRIPTION

Rotator Cuff Repair

I. History/Symptoms

Must meet the following:

A. Severe shoulder pain; and
B. Inability to raise shoulder

AND

II. Physical Findings

Must meet A and B or C

A. Weak or absent abduction; and
B. Tenderness over rotator cuff; or
C. Pain relief with an injection of anesthetic for a diagnostic/therapeutic trial

AND

III. Diagnostic Testing

Must meet one of the following:

A. Positive MRI; or
B. Positive ultrasound; or
C. Positive findings on arthrogram; or
D. Positive findings on previous arthroscopy

AND

IV. Failure to improve with outpatient therapy and conservative treatment for:

A. Acute cases - one to three weeks; **or**
B. Erosive cases
   1. Three months if treatment is continuous; and
   2. Six months if treatment is intermittent

Special Instructions
Cervical pathology and frozen shoulder syndrome should be ruled out prior to an operative procedure.

Level of Care Required
Inpatient

CRITERIA NUMBER 7 - ANTERIOR ACROMIONECTOMY FOR ACROMIAL IMPINGEMENT SYNDROME SHOULDER

NARRATIVE DESCRIPTION

Anterior Acromionectomy

I. History/Symptoms

Must meet the following:

A. Failure to improve with four to six months of conservative treatment; and
B. Pain with active arc motion 90-130 degrees; and
B. Pain at night

AND

II. Physical Findings

A. Positive impingement test and relief of pain with anesthetic injection

AND

III. Radiologic Findings

A. Coraco-acromial x-ray to document status of bony arch.

Special Instructions
None

Level of Care Required
Inpatient - But arthroscopic repair may not require an inpatient stay.

CRITERIA NUMBER 8 - REPAIR OF AC OR CC LIGAMENTS ACROMIO-CLAVICULAR SEPARATION SHOULDER

NARRATIVE DESCRIPTION

Repair of AC or CC Ligaments

I. History/Symptoms

Must meet the following:

A. Localized pain at AC joint

AND

II. Physical Findings

A. Prominent distal clavicle

AND

III. Diagnostic Testing

A. Radiographic findings of separation of AC joint with weight bearing films

AND

IV. Failure of Bracing Treatment

A. Those separations that can not be reduced and held in a brace; or
B. Those separations that do not improve after a one week trial period in a support brace

Special Instructions
None

Level of Care Required
Outpatient or Inpatient depending on patient

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REVIEW CRITERIA
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CRITERIA NUMBER 9 - MUMFORD PROCEDURE
ACROMIO-CLAVICULAR SEPARATION
SHOULDER

NARRATIVE DESCRIPTION

Excision of distal clavicle

I. History/Symptoms

Must meet the following:

A. Failure to improve with 30-60 days of conservative treatment; **and**
B. Pain at AC joint:
   1. Aggravation of pain with motion; **or**
   2. Aggravation of pain with weight carrying

AND

II. Physical Findings

Must meet A and one from B or C

A. Confirmation that separation of AC joint is unresolved; **and**
B. Prominent distal clavicle; **or**
C. Pain relief obtained with an injection of an anesthetic for diagnostic/therapeutic trial

AND

III. Diagnostic Testing

Must meet one of the following:

A. Separation of AC joint with weight bearing films; **or**
B. Severe DJD at AC joint noted on x-ray

Special Instructions
None

Level of Care Required
Outpatient or Inpatient depending on patient

CRITERIA NUMBER 10 - OPEN BANKART OR BRISTOW FOR RECURRENT DISLOCATION SHOULDER

NARRATIVE DESCRIPTION

Open Bankart or Bristow Procedure

I. History/Symptoms

Must meet the following:

A. Multiple recurrent dislocations that inhibit activities of daily living

AND

II. Diagnostic Testing

Must meet one of the following:

X-Ray to:

A. Confirm dislocation; **or**
B. Exclude fracture; **or**
C. Exclude other bony abnormalities

Special Instructions
A second surgical opinion and psychiatric/psychological evaluation will be obtained if this is a second request for this procedure.

Level of Care Required
Inpatient

CRITERIA NUMBER 11 - REPAIR OF BICEPS TENDON
PROXIMAL RUPTURE OF THE BICEPS
SHOULDER

NARRATIVE DESCRIPTION

Repair Biceps Tendon

I. History/Symptoms

Must meet the following:

A. Clinical history of more than normal amount of pain unresolved with attempts to use arm

AND

II. Physical Findings

Must meet the following:

A. Palpable bulge in upper aspect of arm

AND

III. Diagnostic Testing

Not applicable

Special Instructions
Consideration of tenodesis should include the following:

1. *Patient should be a young adult; or*
2. *Procedure should be done in conjunction with another open repair; or*
3. *There should be evidence of an incomplete tear.*

Level of Care Required
Outpatient

CRITERIA NUMBER 12 - REPAIR OF BICEPS TENDON
DISTAL RUPTURE OF THE BICEPS
SHOULDER

NARRATIVE DESCRIPTION

Repair Biceps Tendon

I. History/Symptoms

Must meet the following:

A. Pain

AND

II. Physical Findings

Must meet the following:

A. Inability of physician to palpate the insertion of the tendon at the patient's antecubital fossa

AND

III. Diagnostic Testing

Not applicable

Special Instructions
Should be repaired within one week of injury or diagnosis.

Level of Care Required
Outpatient

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REVIEW CRITERIA
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CRITERIA NUMBER 13 - SHOULDER ARTHROSCOPY FOR DIAGNOSTIC PURPOSES SHOULDER

NARRATIVE DESCRIPTION

Shoulder Arthroscopy for Diagnostic purposes

I. History/Symptoms

Must meet the following:

A. Acute pain; **or**
B. Limitation of function despite conservative treatment

AND

II. Physical Findings

Must meet the following:

A. Diminution of function

AND

III. Diagnostic Testing

Imaging inconclusive

Special Instructions
Request for inpatient setting will be reviewed by a Physician Reviewer.

Level of Care Required
Outpatient

CRITERIA NUMBER 14 - ANTERIOR CRUCIATE LIGAMENT (ACL) REPAIR KNEE

NARRATIVE DESCRIPTION

Anterior Cruciate Ligament (ACL) Repair

I. History/Symptoms

Must meet A and 1 or 2:

A. Instability of the knee (buckling or giving way); and
   1. Significant effusion at the time of injury; or
   2. Description of injury indicating a rotary twisting or hyperextension occurred

AND

II. Physical Findings

Must meet A and 1 or 2 or 3:

A. Positive Lachmans sign; and
   1. Positive pivot shift; or
   2. Positive anterior drawer; or
   3. Positive KT 1000, > 3-5mm = +1
      > 5-7mm = +2
      > 7 mm = +3

AND

III. Diagnostic Testing

Positive findings of one of the following:

A. Arthrogram; or
B. MRI; or
C. Arthroscopy

Special Instructions
None

Level of Care Required
Inpatient

CRITERIA NUMBER 15 - PATELLA TENDON RE-ALIGNMENT MAQUET PROCEDURE KNEE

NARRATIVE DESCRIPTION

Patella Tendon Re-Alignment

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I. History/Symptoms

Must meet the following:

A. Rest-sitting pain

AND

II. Physical Findings

Must meet one of the following:

A. Pain with patellar/femoral movement; **or**
B. Recurrent dislocations

AND

III. Diagnostic Testing

Must meet the following:

A. Recurrent effusions; **and**
B. Patella apprehension; **and**
C. Synovitis; **and**
D. Lateral tracking; **and**
E. Increased Q angle > 15 degrees

Special Instructions
None

Level of Care Required
Inpatient

CRITERIA NUMBER 16 - KNEE JOINT REPLACEMENT

NARRATIVE DESCRIPTION

Knee Joint Replacement

I. History/Symptoms

Must meet all of the following:

A. Limited range of motion; **and**
B. Night pain; **and**
C. No relief of pain with conservative care

AND

II. Physical Findings

Not Addressed in Guideline

AND

III. Diagnostic Testing

Positive findings (significant loss or erosion of cartilage to the bone) of one of the following:

A. Standing x-rays; **or**
B. Arthroscopy

Special Instructions
If 2 or 3 knee compartments are affected a total joint replacement is indicated. If only one knee compartment is affected, a unicompartmental or partial replacement is indicated.

Level of Care Required
Inpatient

CRITERIA NUMBER 17 - LATERAL LIGAMENT ANKLE RECONSTRUCTION FOR CHRONIC INSTABILITY OF ANKLE

NARRATIVE DESCRIPTION

Lateral Ligament Ankle Reconstruction

I. History/Symptoms

Must meet the following:

A. Instability of the ankle

AND

II. Physical Findings

Must meet the following:

A. Positive anterior drawer

AND

III. Diagnostic Testing

Abnormal test results of the following:

Must meet A and B, or C

A. Negative to minimal arthritic joint changes on x-ray; and
B. Positive stress x-rays identifying motion at the ankle or subtalar joint, at least 15° lateral opening at the ankle joint; or
C. Demonstrable subtalar movement

AND

IV. Failure to improve with conservative treatment with:

A. Immobilization with support cast or brace; or
B. Rehabilitation program

NOTE: For either of the above, the time frame will vary dependent on the severity of the injury/trauma.

Special Instructions
None

Level of Care Required
Outpatient or Inpatient depending on patient

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CRITERIA NUMBER 18 - LATERAL LIGAMENT ANKLE RECONSTRUCTION FOR ACUTE ANKLE SPRAIN/STRAIN INVERSION INJURY

NARRATIVE DESCRIPTION

Lateral Ligament Ankle Reconstruction

I. History/Symptoms

Must meet one of the following:

A. Description of inversion; **or**
B. Hyperextension injury with ecchymosis or swelling

AND

II. Physical Findings

Must meet the following:

A. Positive anterior drawer; **and**
   1. Grade 3 injury (lateral injury); **or**
   2. Osteochondral fragment; **or**
   3. Medial incompetence

AND

III. Diagnostic Testing

Abnormal test results of the following:

A. Negative to minimal arthritic joint changes on x-ray; **and**
B. Positive stress x-rays identifying motion at the ankle or subtalar joint, at least 15° lateral opening at the ankle joint; **or**
C. Demonstrable subtalar movement

AND

IV. Failure to improve with conservative treatment with:

A. Immobilization with support cast or brace; or
B. Rehabilitation program

NOTE: For either of the above, the time frame will vary dependent on the severity of the injury/trauma.

Special Instructions
None

Level of Care Required
Outpatient or Inpatient depending on patient

CRITERIA NUMBER 19 - FUSION ANKLE-TARSAL-METATARSAL TO TREAT NON-UNION OR MALUNION OF A FRACTURE OR TRAUMATIC ARTHRITIS SECONDARY TO ON THE JOB INJURY TO THE AFFECTED JOINT

NARRATIVE DESCRIPTION

Fusiont
Ankle-Tarsal
Metatarsal

I. History/Symptoms

Must meet the following:

A. Pain including that which is aggravated by activity and weight-bearing; **and**
B. Pain relieved by Xylocaine injection

AND

II. Physical Findings

Must meet the following:

A. Malalignment; **and**
B. Decreased range of motion

AND

III. Diagnostic Testing

X-ray confirming presence of:

A. Loss of articular cartilage (arthritis); **or**
B. Bone deformity (hypertrophic spurring or sclerosis); **or**
C. Non or mal-union of a fracture

AND

IV. Failure to improve with the following:

A. Casting or bracing; **or**
B. Shoe modification or orthotics; **or**
C. Anti-inflammatory medications

Special Instructions
Supporting imaging could include: Bone Scan (for arthritis only) to confirm localization, MRI, or Tomography.

Level of Care Required
Outpatient

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REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 20 - CONSERVATIVE OUTPATIENT DIAGNOSIS AND TREATMENT OF NECK AND BACK INJURIES ACUTE - UP TO 6 WEEKS FROM DATE OF INJURY UTILIZATION GUIDELINE

NARRATIVE DESCRIPTION

Strain/Sprain of Neck or Back

Acute diagnostic and treatment measures up to 6 weeks from date of injury.

If the patients history reveals any of the following conditions, this criteria would *NOT APPLY*.

A. Concurrent unexplained fever over 48 hours; **or**
B. Neoplasm; **or**
C. Severe trauma; **or**
D. Rheumatoid arthritis; **or**
E. Herniated disk; **or**
F. Spinal stenosis; **or**
G. Spondylolisthesis; **or**
H. Congenital fusion; **or**
I. Diastematomyelia; **or**
J. Hemivertebra; **or**
K. Spinal osteomyelitis; **or**
L. Prior back surgery; **or**
M. Bowel and bladder symptoms; **or**
N. Age over 50

I. Diagnostic Testing Allowed

X-rays (only one examination allowed)

A. Back - maximum 4 views
B. Neck - maximum 5 views

AND

II. Treatment Measures Allowed (with scope of license)

A. Medical office treatment (maximum of 4 visits in the first 6 weeks);
B. Physical therapy (maximum 18 visits in first 6 weeks);
C. Occupational therapy (maximum 6 visits in first 6 weeks);
D. Chiropractic treatment (maximum of 18 visits in first 6 weeks);
E. Trigger point injection (maximum of 2 within 4 weeks);
F. Physical agents (heat/cold, electrical stimulation, biofeedback, iontophoresis/phonophoresis, ultrasound, fluori-methane) maximum of 2 allowed per treatment session - **not allowed if only treatment**

III. Durable Medical Equipment (DME) Allowed

A. Lumbar support
B. Cervical collar

Special Instructions

1. *The following diagnostic tests are not allowed: CT Scan, MRI, Bone Scan, Computer Book Testing (CBT), EMG and Nerve Conduction, Functional Capacity Testing (FCT), Work Capacity Evaluation (WCE), Thermogram, and Myelogram.*
2. *The following treatments are not allowed: Facet Injection, Epidural Block, Back Traction, and TENS.*
3. *Neck Traction is allowed.*
4. *For patients treatment by more than one discipline, (physical therapy, occupational therapy, chiropractic, etc.) services should not be duplicated.*

5. ***Care may be required to extend beyond 6 weeks if continued symptoms are present, but should not exceed 12 weeks from the initial time of injury. Go to criteria 21 if > 6 or < 12 weeks.***

Level of Care Required

Outpatient

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 21 - CONSERVATIVE OUTPATIENT DIAGNOSIS AND TREATMENT OF NECK AND BACK INJURIES SUB-ACUTE - FROM 7 TO 12 WEEKS FROM DATE OF INJURY UTILIZATION GUIDELINE

NARRATIVE DESCRIPTION

Strain/Sprain of Neck or Back

Subacute Diagnostic and Treatment Measures: (From 7-12 weeks from data of injury)

Treatment can be extended beyond 6 weeks if one of the following conditions are met:

A. Severe symptoms over 2 weeks without treatment; **or**
B. Severe symptoms unimproved over 3 weeks with treatment; **or**
C. Back to work full time with persistent symptoms; **or**
D. Chemical dependency; **or**
E. Emotional distress documented by psychologic evaluation or physical findings (hysterical or Waddell signs); **or**
F. Over 3 prior attacks of back pain; **or**
G. Heavy lifting (50 pounds) or constant sitting job; **or**
H. Pregnancy (over 5 months); **or**
I. Sacralization, asymmetric facet, segmental instability

I. Diagnostic Testing Allowed

None

AND

II. Treatment Measures Allowed

A. Medical office treatment sessions (maximum of 2 visits between weeks 7 and 12);
B. OT Rx sessions (10 visits between weeks 7 and 12);
C. Physical therapy treatment sessions (maximum 10 visits between weeks 7 and 12);
D. Chiropractic treatment sessions (maximum 10 visits between weeks 7 and 12);
E. Trigger point injection (maximum of 1 in weeks 7 and 12);
F. Physical agents (heat/cold, electrical stimulation, biofeedback, iontophoresis/phonophoresis, ultrasound, fluori-methane) maximum of 2 allowed per treatment session - **not allowed if only treatment**

Special Instructions

1. *For patient treated by more than one discipline (physical therapy, occupational therapy, allopathic medicine, and chiropractic), similar services should not be duplicated.*
2. *The following diagnostic tests are not allowed: Bone Scan, EMG, Thermogram, and Myelogram.*
3. *The following treatments are not allowed: TENS, and Back Traction.*
4. *Neck Traction is allowed.*

Level of Care Required

Outpatient

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 22 - SURGERY FOR CERVICAL RADICULOPATHY FOR ENTRAPMENT OF A SINGLE NERVE ROOT

NARRATIVE DESCRIPTION

Cervical:
- Laminectomy
- Diskectomy
- Laminotomy

Foraminotomy with or without fusion, excluding fracture

I. History/Symptoms

Sensory symptoms in a dermatomal distribution such as:

A. Radiating pain; **or**
B. Paresthesia; **or**
C. Tingling; **or**
D. Burning sensation; **or**
E. Numbness

AND

II. Physical Findings

Must meet one or more of the following:

A. Dermatomal sensory deficit; **or**
B. Motor deficit; **or**
C. Reflex changes; **or**
D. Positive EMG

AND

III. Diagnostic Testing

Abnormal test results that correlate with the level of nerve root involvement consistent with history and physical findings such as:

A. CT scan; **or**
B. MRI; **or**
C. Myelogram

AND

IV. Failure to improve with a minimum of 6 to 8 weeks of conservative treatment:

For Example:

A. Physical modalities; **and/or**
B. Non-steroidal anti-inflammatory agents; **and/or**
C. Cervical traction

Special Instructions

1. *Refer cases that fall into the following range:*
   a. *repeat surgery at the same level*
   b. *request for surgery at the C3-4 level*
   c. *request for surgery with signs and symptoms indicating myelopathy*
   d. *any case not meeting criteria*
2. *When requesting authorization for decompression of multiple level nerve roots, each level is subject to the criteria.*

Level of Care Required

Inpatient

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 23 - DIAGNOSIS AND OUTPATIENT TREATMENT OF A SINGLE LUMBAR SPINAL NERVE ROOT ENTRAPMENT

NARRATIVE DESCRIPTION

Herniated Lumbar Disk

I. History/Symptoms

Must meet one of the following:

A. Radicular pain within nerve root distribution; or
B. Bowel and bladder dysfunction; or
C. Weakness or sensory disturbance in limb

AND

II. Physical Findings

One required to be positive in order to proceed with diagnostic test.

A. Atrophy of calf or thigh; or
B. Segmental motor loss; or
C. Femoral stretch test positive; or
D. Knee or ankle reflex (including posterior tibial) decrease; or
E. Sensory loss in distribution of nerve root pattern; or
F. Positive straight leg raising producing leg pain confirmed in sitting and supine position

III. Allowed Diagnostic Testing

Maximum of three tests performed if results negative.

A. Low back x-rays if not done since injury (should precede B through F); or
B. CT scan; or
C. MRI; or
D. Myelogram; or
E. Bone scan; or
F. EMG

NOTE: E and F above should not be used as the only diagnostic test.

IV. Treatment Measures

(Maximum duration of treatment in six months from data of injury)

A. Epidural steroid injection (maximum of 3); **and/or**
B. Physical therapy (maximum of 42 visits); **and/or**
C. Occupational therapy (maximum of 6 visits); **and/or**
D. Chiropractic treatment (maximum of 42 visits); **and/or**
E. Facet injection (maximum 3); **and/or**
F. Physician office treatment sessions (maximum of 12); **and/or**
G. Physical agents (heat/cold, electrical stimulation, traction, biofeedback, iontophoresis/phonophoresis, ultrasound, fluori-methane) maximum of 2 allowed per treatment session - **not allowed if only treatment**

Special Instructions

1. *For patient treated by more than one discipline, (physical therapy, occupational therapy, chiropractic, etc.) services should not be duplicated.*
2. *The following diagnostic tests are not allowed: Myeloscopy, Discography, and Somatosensory Evoked Potentials Thermography.*

Level of Care Required

Outpatient

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 24 - OPERATIVE TREATMENT OF A SINGLE LUMBAR SPINAL NERVE ROOT ENTRAPMENT

NARRATIVE DESCRIPTION

Lumbar:
- Laminectomy
- Laminotomy
- Foraminotomy
- Micro-Diskectomy
- Diskectomy
- Lumbar Fusion

I. History/Symptoms

Must meet one of the following:

A. Radicular pain within nerve root distribution; **or**
B. Bowel and bladder dysfunction; **or**
C. Weakness or sensory disturbance in limb; **or**
D. Inability to control pain on an outpatient basis; **or**
E. Inability to maintain activity required for outpatient status because of non-supportive home situation

AND

II. Physical Findings

Must meet A and one from B:

A. Radiating (radicular) leg pain greater than back pain; **and**
B. Evidence of neurologic deficit in the distribution of a single lumbar spinal nerve such as:
   1. Motor deficit (e.g., foot drop or quadriceps weakness); **or**
   2. Sensory deficit; **or**
   3. Reflex changes; **or**
   4. Positive EMG

AND

III. Diagnostic Testing

One test must demonstrate nerve root compression:

A. MRI; **or**
B. CT scan; **or**
C. Myelogram;

OR

IV. Post Hospital Treatment Allowed

A. Office visits - 5 in first 4 months
B. Physical therapy treatment sessions maximum 24 visits
C. Occupational therapy - maximum 6 visits
D. Chiropractic sessions - maximum 24 visits
E. Physical agents (heat/cold, electrical stimulation, biofeedback, iontophoresis/phonophoresis, ultrasound, flouri-methane) maximum of 1 allowed per treatment session - not allowed if only treatment - generally de-emphasized

Special Instructions

1. *Length of stay postoperatively is 0-5 days (7 days for spinal fusion).*
2. *For patients treated by more than one discipline (physical therapy, occupational therapy, allopathic medicine, and chiropractic) similar services should not be duplicated.*

Level of Care Required

Inpatient

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

REVIEW CRITERIA
EFFECTIVE JULY 1, 1993

CRITERIA NUMBER 25 - CAUDA EQUINA SYNDROME

NARRATIVE DESCRIPTION

Lumbar:
- Laminectomy
- Diskectomy
- Micro-Diskectomy

I. History/Symptoms

A. Sudden onset or rapid progression of sensory symptoms

AND

II. Physical Findings

Must meet one of the following:

Neurologic exam showing:

A. Deficit that is bilateral; or
B. Involves multiple neurologic levels

AND

III. Diagnostic Testing

Must meet one of the following:

Positive finding demonstrating a large lesion producing central-stenosis with tight obstruc...

A. CT scan; or
B. MRI; or
C. Myelogram

Special Instructions
Early surgical intervention.

Level of Care Required
Inpatient